

FILED DEC 13 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

37932  
State File No. 39

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 198 PRIMARY REG. DIST. NO. 4316 Registrar's No. 39

1. PLACE OF DEATH a. COUNTY <b>MACON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>MISSOURI</b> b. COUNTY <b>MACON</b>	
b. CITY OR TOWN <b>NEW CAMBRIA</b> (If outside corporate limits, write RURAL and give township)		c. CITY OR TOWN <b>NEW CAMBRIA</b> (If outside corporate limits, write RURAL and give township)	
c. LENGTH OF STAY (in this place) <b>life</b>		d. STREET ADDRESS <b>no.</b> (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>1</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>HANNAH</b>		b. (Middle) _____ c. (Last) <b>VANTINE</b>	
4. DATE OF DEATH <b>NOVEMBER 16, 1949</b> (Month) (Day) (Year)			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>NOV. 15 1867</b>
9. AGE (in years last birthday) <b>82</b>	IF UNDER 1 YEAR Months _____ Days <b>1</b>	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (State or foreign country) <b>Ohio</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13a. FATHER'S NAME <b>THOMAS L. JENKINS</b>		13b. MOTHER'S MAIDEN NAME <b>JANE EDWARDS</b>	14. NAME OF HUSBAND OR WIFE <b>THOMAS VANTINE</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>no.</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Sadie Lewis, Marcelline, Mo.</b> ADDRESS _____
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Chronic Myocarditis</b> <b>Cerebral Myoplegia</b> <b>Chronic Hypertension</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. _____	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____	
22. I hereby certify that I attended the deceased from <b>March 11, 1948</b> , to <b>Nov 16, 1949</b> , that I last saw the deceased alive on <b>Nov. 16, 1949</b> , and that death occurred at <b>10 P. m.</b> , from the causes and on the date stated above.			
23a. SIGNATURE <b>G. H. Massey, M.D.</b> (Occupation or title)		23b. ADDRESS <b>Macon, Mo.</b>	23c. DATE SIGNED <b>11/21/49</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>Nov. 19, 1949</b>	24c. NAME OF CEMETERY OR CREMATORY <b>New Cambria Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>New Cambria, Mo.</b>
DATE REC'D BY LOCAL REG. <b>11-25-49</b>	REGISTRAR'S SIGNATURE <b>Josephine King</b> 397	25. FUNERAL DIRECTOR'S SIGNATURE <b>H. E. Hillland</b> ADDRESS <b>New Cambria, Mo.</b>	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED 12/11/49  
MACON COUNTY HEALTH DEPARTMENT  
County File No. 12/49/50  
Date Filed 12/12/49

STATEMENT BY LICENSEE STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Student Embalmer

Signed *H. F. Lilliland*

Licensed Embalmer No. 4019

P. O. Address *New Cambria Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.